Independent Advisory Group
on Sexual Health and HIV

ANNUAL REPORT
2006|2007

WHY SEXUAL HEALTH IS A CROSS GOVERNMENTAL ISSUE

Contents

SECTION FOUR – HEALTH PROMOTION

Chair's Introduction

This year, the IAG has found it necessary to take a fresh look at the National Strategy for Sexual Health and HIV because the fast-changing landscape of the NHS is having a profound impact on sexual health services.

Now, more than ever, it is important to have 'whole society' approval and involvement in sexual health services. Recent changes in commissioning, service provision and health promotion mark the need for a truly cross governmental approach. Sexual health will be as much a part of the fabric of local government as it is of local healthcare provision. For this reason, this report is titled 'why sexual health is a cross governmental issue'.

A focus on regional and local commissioning marks the next phase as services devolve into the community. The process is challenging and complex. Significant issues in relation to sexual health services around Payment by Results and Practice Based Commissioning continue to be debated while the roll out continues.

We have spoken with optimism about the devolvement of commissioning. This year the Annual Report reviews some of the key considerations that must be borne in mind by those who are commissioners, and by those who are responsible for commissioners.

Before the running of services is entirely devolved to localities, there is a duty by Government to ensure that the basic tools are in place to help commissioners do their jobs. This report outlines what some of those might be.

Decentralisation paradoxically requires strong centralisation of certain elements and principals such as equity of access – avoiding postcode lottery – and having quality, choice and cost effectiveness. Data collection, coherent gathering of results, understanding of local service provision and on-going assessment and implementation of outcomes are vital to meet the public health imperative of full coverage of services.

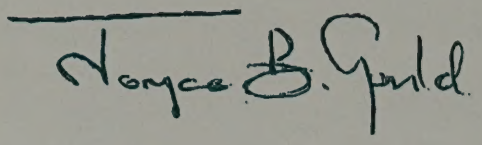
There is also a political imperative. The understanding and awareness of cost at point of delivery (both in terms of economics and health benefit) is vital, as is popular support from the public, the voluntary sector and other key stakeholders.

The proposed merging of all budgets relating to sexual health services is designed to encourage a move away from a 'silo' mentality that dogs sexual health services towards genuine delivery and attendant accountability across the full spectrum of services. We strongly advise guidance be placed on the allocation of this budget towards health promotion as we are deeply concerned that these monies will be otherwise subsumed.

The public health reform discussed in this report is a significant part of the legacy of this Government.

The IAG would like to see this reform contribute towards bringing down rates of STIs, HIV and abortion, and be part of the solution in self management to promote good sexual health.

This will be only achieved if the devolvement of local and regional services is implemented with intelligence and, above all, with integrity.



Baroness Gould of Potternewton

Why Sexual Health is a Cross Governmental Issue

Executive Summary

The Annual Report is divided into four sections:

1) A review of the current NHS landscape, with particular focus on issues that will affect the next round of commissioning for 2008/09 onwards.
2) An update on diagnosis and treatment of HIV.
3) An analysis of sexual health services in the community – new developments and opportunities for improved service provision.
4) A focus on health promotion, young people, education and awareness raising, including PSHE, the HPV vaccine and the normalisation of condoms.

The role of the IAG is to monitor and advise the Government on the implementation of the National Strategy for Sexual Health and HIV.

The landscape in which sexual health services exist has changed. The merging of health and social care within Local Authorities and the increased powers of local authorities to be 'place shapers' is very important in terms of improving health and social care for people, including those with HIV.

Interventions

Intervention	Department	Page
Commissioning		
1. That the Government ensure performance indicators relating to HIV, contraception and abortion (both early and late) are included in the NHS Outcomes Framework and Local Area Agreements.	Department of Health Department of Communities and Local Government	16
2. That the Government advise Strategic Health Authorities (SHAs) to ensure that Primary Care Trusts (PCTs) bring together budgets for all sexual health services including GUM, contraception and abortion, and commission from this central budget across SHA areas.	Department of Health	16
3. That sexual health promotion forms a specific, identified percentage of the central budget, and that tariffs are developed and implemented, and the Department of Health issue guidance on the appropriate amounts against the results of the needs assessment.	Department of Health	16
4. That sexual health services have named champions at board level within their PCTs, support from Financial Directors and involvement from senior level clinicians.	Department of Health	16
5. That GUM clinic access remains a priority.	Department of Health	17
Training Commissioners		
6. That the Government instigate a programme of training for commissioners in basic commissioning skills, and that it includes a specific section on commissioning for sexual health.	Department of Health	17
7. That the Government commissions and shares best practice in terms of: • analysing data. • developing model Service Level Agreement contracts across all sexual health and HIV care pathways. • providing model templates for commissioning sexual health for PCTs which take account of the needs assessment results. • providing a framework for benchmarking which includes an appropriate spend based on best practice.	Department of Health	17

Intervention	Department	Page
Data		
8. That the Government: a) work to merge data sources from general practice, community contraceptive clinics, pharmacies, NGOs and GUM clinics to provide a holistic, up-to-date view of sexual health issues on a PCT basis. b) ensure real-time data collection is the ultimate priority in the review of data collection. c) review current data surveillance collection systems to ensure it sits with commissioning. d) develop and coordinate cross departmental sexual health/HIV performance score card to be used by SHAs and PCTs to pull all commissioning on sexual health together.	Department of Health	18
Networks		
9. That sexual health commissioning networks are encouraged and fostered as a key part of the commissioning process.	Department of Health	19
10. That all sexual health commissioning networks have PCT chief executive or PCT board level representation on them.	Department of Health	19
National Support Team		
11. That the National Support Team produce an overview of positive interventions so that best practice can be shared.	Department of Health	19
12. That the role of the National Support Team be considered in relation to other areas of sexual health provision, for example, in terms of contraceptive services.	Department of Health	19
HIV		
13. That the Government instate an HIV performance indicator relating to reducing late diagnoses of HIV (see intervention 1).	Department of Health	22

Intervention	Department	Page
14. That the Government encourage primary and community providers to increase HIV testing to bring down rates of undiagnosed HIV/late diagnosis.	Department of Health	22
15. That Government consider including HIV in the list of exemptions from NHS charges relating to STIs as the public health benefits of free treatment to control infections outweighs the financial benefits of withholding free treatment.	Department of Health	22
General Practice		
16. That GPs provide increased screening for HIV and other STIs.	Department of Health	25
Contraceptive Services		
17. That the Government protects the role of community contraceptive clinics as trainers, service providers and clinical governance leads for the primary care community.	Department of Health	27
18. That the Government ensures robust commissioning frameworks to implement tariff and dehosting of the funding arrangements to improve procurement of contraceptive services.	Department of Health	27
19. That the Government ensures contraception forms an integral part of commissioning post-abortion care.	Department of Health	27
Nurses		
20. That the Government engages with the Nursing and Midwifery Council on modernising nursing careers, and where sexual health should be developed.	Department of Health	27
21. That the Government advise that the skills of nurses and other practitioners in general practice are updated and maintained in sexual health and contraception.	Department of Health	27

Intervention	Department	Page
Voluntary Sector		
22. That Government commit to providing central funding to voluntary organisations.	Offices of the Third Sector	29
23. That the Compact has greater powers to influence processes around commissioning, and attention is paid to sexual health contracts between the Government and Voluntary Sector.	Offices of the Third Sector	29
24. That the Government supports the continuation of the AIDS Support Grant.	Department of Health	29
Condoms		
25. That the guidance around condom advertising is reviewed.	Department for Business, Enterprise and Regulatory Reform	31
26. That the Commercial Directorate procures condoms for as much of the NHS as possible to increase access and get better value.	Department of Health	31
Young People		
27. That the Government ensures that sex and relationships education is a statutory part of PHSE.	Department for Children, Schools and Families	33

SECTION ONE

1.0 Review of The National Strategy for Sexual Health and HIV

The NHS reforms that include PCT structure and commissioning continue to be implemented. We are operating in a very different environment from when the National Strategy for Sexual Health and HIV was published in December 2001, and the implementation action plan was published in June 2002.

The IAG has commissioned MedFASH to consider the impact of the Strategy, review developments since publication and make recommendations for the future.

The review will highlight:

- Policy changes (e.g. strengthened commissioning and health reform)
- Structural changes (e.g. devolution of decision making, NHS reconfiguration)
- Service delivery changes (e.g. plurality of service delivery, integration of services)
- Clinical changes (e.g. development of the role of nurses and pharmacists, treatment practices)

The review of the Strategy is to be published in Spring 2008.

2.0 Sexual Health and Commissioning

Good commissioning is the strategic planning, procurement and monitoring of services based on population need. It should reduce inequalities and achieve value for money.

The strategic approaches outlined in Shifting the Balance of Power,[1] Choosing Health White Paper,[2] Our Health, Our Care, Our Say,[3] Staying Healthy,[4] Strong and Prosperous Communities – the Local Government White paper,[5] the new LAA Indicators and the NHS Health and Social Care Outcomes Framework suggest the way sexual health services should be commissioned for the foreseeable future.

Lord Darzi, Parliamentary Under Secretary of State for Health, is producing a national review of the NHS which will have an impact on public health service provision.

1 Shifting the Balance of Power- The Next Steps, 4 January 2002, Author: Department of Health Gateway: 2002, Product Code: 26434, Copyright: Crown.
2 Choosing Health: Making Healthy Choices Easier, 16 November 2004, Author: Department of Health, Gateway: 4135, Product Code: 264714, Copyright: Crown
3 Our Health Our Care Our Say: a new direction from community services, 30 January 2006. Author: Department of Health, ISBN: 0101 673728, Series No. cm 6737, Copyright: Crown
4 Staying Healthy Working Group Report, Healthcare for London, a Framework for Action, http://www.healthcareforlondon.nhs.uk/documents/Staying_healthy.pdf
5 Strong and Prosperous Communities – The Local Government White Paper, October 2006, TSO (The Stationery Office) ISBN 010 1693923, Copyright: Crown

This section focuses on issues around commissioning, with an emphasis on how to achieve a positive impact on services from 2008 onwards.

Considerations for Commissioning

- **Leadership - seniority and clout within the PCT, competence and recognition of commissioners**
- **Performance indicators**
- **Data set and monitoring**
- **Local Government levels of understanding, support and compliance**

2.1 Leadership – Seniority and Clout within the PCT, Competence and Recognition of Commissioners

Leadership is the key issue in commissioning all sexual health services, and that leadership is necessary at all levels whether national, regional, or local.

Within the NHS, sexual health services will need *named champions* at board level within their PCTs, and support from Financial Directors. Involvement from senior level clinicians is vital to ensure that the commissioner understands the complexities, standards and issues that are at stake.

There also needs to be influential sexual health champions across local government. Local Area Agreements and public involvement through the Patient and Public Involvement agenda will help shape services at a local level that reach across health, social care and services, and education.

2.2 Bringing Services Together

PCTs are rapidly separating their commissioning and provider functions and, in some instances, seeking new providers for their community services. This has added uncertainty and instability for certain services – for example, community contraceptive services.

The IAG is concerned that there is a danger that the powerful economic arguments behind strong sexual health and contraceptive services will be lost unless these services are represented at the most senior level within PCTs.

The financial case for sexual health services has been made repeatedly. This resulted in Government placing 48 hour GUM access in its top six priorities, and allocating £300 million funding to support Choosing Health White Paper - an act which was sadly nullified by the financial imperative for PCTs to balance books which meant that most of the funding failed to reach intended services.[6]

In the last two years the Department of Health commissioned the *Health Economics of Sexual Health, a guide to commissioning and planning*[7] which

6 Choosing Sexual Health, where did the money go? IAG on Sexual Health and HIV, 26 July 2006
7 Payne, N and O'Brien R, Health Economics of Sexual Health: A guide to Commissioning and planning, September 2005

outlined the level of cost effectiveness on a service by service level. *fpa* published its definitive report, *The Economics of Sexual Health*,[8] on how services help save NHS money by preventing unintended pregnancies and sexually transmitted infections.

However, it is not enough to prove the case at national level. It has to be proved locally. This requires champions who can influence budget holders, and the IAG is concerned that, as commissioners currently stand, there is not that level of influence.

Commissioning should take place across the pathway from prevention to treatment at the most appropriate level of service delivery. The IAG believes that there are benefits in merging the budgets for all sexual health and contraceptive services (including health promotion).

The boundaries between acute sector care and what is delivered in the community are being eroded (as a matter of policy as well as practice) so the positioning of the budget should reflect this.

If contraception and abortion services are commissioned together, then the benefits that health economists have promised will be seen in reality.[9] This should bring increased recognition of the benefits of investment in contraception. Strong contraceptive services should bring the economic benefit of a reduced abortion rate.

Early and improved rates of diagnosis of HIV can be associated with increased testing in community settings and improved awareness and understanding among health professionals like doctors, nurses, health visitors, and community outreach.

The levelling off of STI rates can be linked to improved health education, easy access to condoms and good, targeted health promotion – an important aspect of public health so often lost in the current commissioning debate.

2.3 Collaborative Commissioning

There is a balancing act between empowering localities to commission the services that they need for their area, and avoiding a post code lottery.

Equitable provision and access of quality services is important to a public health programme for sexual health.

However, getting parity of services between regions while still meeting the needs of the locality is important. It is also where commissioning networks can be extremely powerful – for example in the sharing of best practice and 'bulk buying' of services and products.

Payment by Results (PBR) should help with this, provided the tariff is appropriate. At the moment, revised tariffs for contraceptive services and abortion services are being developed and piloted in London.

8 The Economics of Sexual Health, Armstrong N, Donaldson C and Davey, C, Newcastle University on behalf of *fpa* 2005

9 The NHS could save £1 billion in 15 years by investing in community contraception clinics and by speeding up women's access abortion services by 10 days, *fpa*, ibid

2.4 Training Commissioners

Effective commissioning is a skill set that can be taught. It includes negotiation skills, communication skills and financial skills. Sexual health commissioners must be able to use data as part of their argument (discussed in section 4.0 on data), and have advice on and understand population health need.

Commissioners should receive training in these skills in order to maximise their impact on commissioning in relation to their budget – which traditionally is low.

It is a nuanced role which addresses the needs of a great number of different stakeholders, participants, and clients.

Commissioners should also be participating in sexual health networks that can address issues like capacity building, sharing best practice, governance, training, as well as 'do once and share' information and procurement issues

The IAG recommends that the Government produce training that specifically meets the needs of commissioners, including addressing the specific needs of those who are commissioning sexual health.

3.0 Performance Indicators

The Joint Strategic Needs Assessment will play a pivotal role in commissioning and priority setting. To have any priority within the local area commissioning, sexual health indicators must be amongst those chosen by an economy as part of its Local Area Agreement (LAA) and be included in the NHS Outcomes Framework.

Nationally, sexual health targets and services have been monitored by the Health Protection Agency and the Healthcare Commission as well as through mandatory data collection to the Department of Health through Unify.

3.1 NHS Indicators

As local regions develop their role as place shapers[10] the importance of the presence of sexual health in the 200 Local Area Agreement (LAA) indicators, and within the NHS Outcomes Framework cannot be underestimated. After consultation among stakeholders, the Department of Health has suggested an indicator around Chlamydia be included in NHS indicators.

An indicator on Chlamydia prevalence supports the work of the Chlamydia screening programme and should include GUM and contraceptive clinic data, as well. Diagnosed cases will be taken as a proxy for prevalence of Chlamydia in a community, which will in itself be a proxy for STIs in a community. The IAG would welcome this indicator.

10 Strong and Prosperous Communities – The Local Government White Paper, October 2006, TSO (The Stationery Office) ISBN 010 1693923, Copyright: Crown

The IAG is very concerned that there are no indicators relating to HIV, contraception or abortion (both early and late) in the NHS set and believes that it is essential that these areas are not overlooked.

Late abortion must be addressed in the indicators. There is a need for quality, appropriate, speedy and humane services for the relatively static number of women accessing abortion after 14 weeks. To ignore the needs of these women, who are making the most difficult of decisions, is a travesty.[11]

Access to GUM clinics must also remain a priority. The 48 hour access target has been an important lever that has focused attention on STI care. The improvements of the last few years should be sustained and built on. There is still a great deal to do to ensure appropriate GUM access.

The Health Protection Agency[12] (HPA) recently issued a warning that increased pressures on GUM services may jeopardise reaching the 48 hour access target identified in the NHS priorities for 2006/07. The HPA also shows a 6 per cent increase in GUM workload between 2005 and 2006.[13]

GUM clinics are major providers of both STI and HIV diagnosis and treatment, and clinical teaching and training for both primary care and other providers. It is imperative that the offer of a GUM appointment within 48 hours is available to 100 per cent.

Interventions on Commissioning

1. That the Government ensure performance indicators relating to HIV, contraception and abortion (both early and late) are included in the NHS Outcomes Framework and Local Area Agreements. **(Department of Health/ Department of Local Communities and Local Government)**

2. That the Government advise Strategic Health Authorities (SHAs) to ensure that Primary Care Trusts (PCTs) bring together budgets for all sexual health services including GUM, contraception and abortion, and commission from this central budget across SHA areas. **(Department of Health)**

3. That sexual health promotion forms a specific, identified percentage of the central budget, and that tariffs are developed and implemented, and the Department of Health issue guidance on the appropriate amounts against the results of the needs assessment. **(Department of Health)**

4. That sexual health services will have named champions at board level within their PCTs, support from Financial Directors and involvement from senior level clinicians. **(Department of Health)**

11 "Recommendation 1: The Department of Health should develop, with the relevant professional bodies and the Healthcare Commission, an agreed best practice protocol for dealing with late gestation abortion cases, to be adopted by the NHS and all independent sector providers. This needs the same emphasis on early abortions." An investigation into the British Pregnancy Advisory Service (BPAS) response to requests for late abortions: a report by the Chief Medical Officer, 21 September 2005, Gateway 5463, Copyright: Crown

12 Health Service Journal, July 26, 2007 HPA warning on Health Target

13 Ibid

5. That GUM clinic access remains a priority. **(Department of Health)**

6. That the Government instigate a programme of training for commissioners in basic commissioning skills, and that it includes a specific section on commissioning for sexual health. **(Department of Health)**

7. That the Government commissions and shares best practice in terms of:

   - analysing data.
   - developing model Service Level Agreement contracts across all sexual health and HIV care pathways.
   - providing model templates for commissioning sexual health for PCTs which take account of the needs assessment results.
   - providing a framework for benchmarking which includes an appropriate spend based on best practice.

   (Department of Health)

4.0 Data

The Department of Health has been reviewing the data requirements of sexual health services. There is a need for data to be as up to date as possible – in an ideal world it would be 'real time'. There is also a need to integrate data from Genitourinary Medicine (GUM) services, GP surgeries, community contraceptive services and any other commissioned sexual health services.

Data should allow for the identification of high risk and vulnerable groups and/or localities so that these can be targeted. Data on patient choice and access also need to be captured by data sets.

Good quality data has been conspicuously lacking in many sexual health services. A recent report by the Healthcare Commission[14] pinpointed data collection as a major issue affecting service delivery.

At the moment there are huge gaps in sexual health data – for example an estimated 50 per cent of KT 31 returns from contraceptive services are not computerised and there are fears that a significant number of visits and activities during visits are under reported.

In terms of monitoring access to GUM clinics, current work underway includes the continued roll-out of GUMAMM,[15] an extension to Unify, to include more detailed information about HIV diagnosis, DNA rates and uptake of appointments. This information will be monthly.

Also from GUM clinics, KC 60 has been reviewed to now give data on ethnicity, sexual orientation and country of birth, and will be reported quarterly through the

14 Performing better? A focus on Sexual Health Services in England, Healthcare Commission June 2007
15 Gentio-Urinary Medicine Access Monthly Monitoring Target

HPA. The new KC 60 will include individual (anonymised) diagnosis which will provide a detailed breakdown to PCT level, and below.

The Department of Health is re-evaluating KT31, the reporting system for community contraceptive clinics. It is in the process of piloting a new and considerably extended form to ensure data is collectable and reportable.

The Department is also investigating the best way of extracting information about STI diagnosis from GPs, given sexual health is not reported through the QOF.

The Department will also review ways of merging information collected from general practice with data from community contraceptive clinics and any other commissioned sexual health services, and link with Connecting for Health.

Interventions on Data Collection

8. That the Government:

a) work to merge data sources from general practice, community contraceptive clinics, pharmacies, NGOs and GUM clinics to provide a holistic, up-to-date view of sexual health issues on a PCT basis.

b) ensure real-time data collection is the ultimate priority in the review of data collection.

c) review current data surveillance collection systems to ensure it sits with commissioning.

d) develop and coordinate cross departmental sexual health/HIV performance score card to be used by SHAs and PCTs to pull all commissioning on sexual health together.

(Department of Health)

5.0 Sexual Health Commissioning Networks and Information Sharing

Sexual health networks can offer one of the best forums for easing sexual health services out of their various silos and encouraging the sharing of information.

The IAG would like to see local networks of quality assured service providers that work under a common clinical governance framework.

Networks can be an invaluable tool for commissioners. However, there is no defined network 'format'. This is understandable because people appear to network in so many different ways.

The IAG supports methods of sharing information and creating care pathways which join up strategic commissioning with PCTs and stakeholders. The IAG is undertaking a work stream to review networks and their formats in the near future.

Interventions on networks

9. That sexual health commissioning networks are encouraged and fostered as a key part of the commissioning process. **(Department of Health)**

10. That all sexual health commissioning networks have PCT chief executive or PCT board level representation on them. **(Department of Health)**

6.0 The National Support Team

The Department of Health established the National Support Team (NST) for sexual health services that are struggling to meet access targets.

The team's main focus has been on reviewing GUM services and meeting the 48 hour access target but within this – and within the spirit of the original GUM access target – there has been an effort to review sexual health services in a holistic way, which includes the provision of services such as contraception.

There have been a number of reported benefits of the work of the NST in terms of holding a mirror up to each service, and also in the sharing of ideas and best practice from other sexual health services. Effectively, the NST seems to facilitate the sharing information and best practice – much as a good network would.

The NST has produced a welcome guide on how PCTs can undertake sexual health needs assessments (SHNA). This is helpful in structuring services. However, the sexual health needs assessment is not mandatory.[16]

While there is some follow up after NST visits, the IAG recommends an overview of what interventions work best, what PCTs struggle with most and how this can be overcome so that the best practice and interventions recommended by the NST can be shared.

The NST for sexual health is one of the few 'monitoring' bodies currently looking at sexual health, and the IAG recommends that its role be considered in relation to other areas of sexual health provision, for example in terms of contraceptive services.

Interventions on the National Support Team

11. That the National Support Team produce an overview of positive interventions so that best practice can be shared. **(Department of Health)**

12. That the role of the National Support Team be considered in relation to other areas of sexual health provision, for example, in terms of contraceptive services. **(Department of Health)**

16 Sexual Health Needs Assessments – A 'How To' Guide commissioned by the Department of Health's National Support Teams for Sexual Health and Teenage Pregnancy, Department of Health, published by Design Options

7.0 A Focus on HIV and AIDS

In response to the complex and challenging environment around HIV and AIDS in England today, the IAG recently hosted a seminar of expert witnesses, and will be publishing its findings later in the year.

In the meantime, some of the recommendations from the seminar, and from the IAG's work throughout the year, are captured here.

7.1 Increasing Diagnoses

The successes and advancement in the medical treatment for HIV and AIDS has led to complacency about the condition. For many, a diagnosis of HIV or AIDS no longer means certain death. HIV/AIDS is perceived as a chronic condition by the public. The IAG is concerned that safer sex messages are being ignored.

The epidemic is increasing in this country, and the spread is not confined to major conurbations. It is nationwide. HIV prevention should be a public health priority.

It is estimated there are 63,500 people living with HIV in this country, a third of which are undiagnosed. Rates of infection are increasing in men who have sex with men, and within certain communities. Yet within the NHS, HIV does not warrant its own NHS performance indicator and very little has been done to normalise diagnosis of HIV – for example by substantially increasing access to HIV testing.

The Chief Medical Officer and Chief Nursing Officer jointly sent a letter[17] to all GPs encouraging awareness of the virus, and suggesting that patients be invited to accept HIV testing if they present with a condition associated with the virus.

The letter quotes the BHIVA audit[18] of HIV-related deaths among adults, which reported that in around a quarter of cases diagnosis occurred too late for effective treatment. Late diagnosis accounted for at least 35 per cent of HIV related deaths.

The IAG welcomes this letter as the first step towards improving diagnosis rates by 'normalising' HIV testing through thoracic medicine (TB), gastroenterology, oncology, dermatology, haematology, emergency medicine and general practice.

Within community provision, substance misuse services should also be using HIV testing as a norm.

17 Sir Liam Donaldson and Professor Christine Beasley, 13 September 2007
18 Submitted for publication, http:www.bhiva.org/files/file1001379.ppt

7.2 The 'Whole Society' Approach

HIV/AIDS is going to be part of the fabric of our society until a cure is found.

For many, the condition is held in abeyance by a cocktail of drugs.

Increased numbers of people with HIV are living a 'normal' lifespan which will bring a number of other issues into relief - like pensions, housing and managing the condition in old age.

This will also present challenges around social care. The IAG believes that the Government should maintain the Aids Support Grant which has enabled local authorities to commission or provide appropriate care for people living with HIV. IAG members are concerned that the allocation of the grant has not increased to meet the growing demand place upon social care organisations.

Public understanding about HIV and AIDS is often tainted with associations of shame and blame. This continued stigma is a barrier to normalising testing, and a blight for day to day existence for those who have the virus.

On the positive side, legislative acts like the Disability Discrimination Act, the introduction of civil partnerships and the repeal of Section 28 represent the integration of gay and bisexual relationships into mainstream society.

On the negative side, media interest has lessened, the HIV and AIDS voluntary sector's funding is under threat, and guidance is currently being considered by the Crown Prosecution Service to instigate criminal prosecution for the transmission of HIV (and other STIs) which health professionals greatly fear will drive the disease further underground.

There are enormous sensitivities when working with immigrant communities and failed asylum seekers around charging for treatment – not to mention getting messages around early diagnosis and other health promotion and prevention messages into the communities.

7.3 Commissioning and HIV

As mentioned previously, there is no performance indicator against HIV, and the IAG believes that there should be one in place around reducing late diagnoses of HIV.

Earlier diagnosis would:

- Reduce level of undiagnosed HIV in the population.
- Enable people to be supported to make behavioural change to avoid infecting others.
- Some people may have infectivity reduced due to earlier treatment with antiretroviral drugs (ART).
- Reduce lengthy inpatient stays, use of A&E services and opportunistic infections.

- The risk of AIDS/symptomatic HIV can be reduced (BHIVA audit showed that 35 per cent of all HIV-related deaths are in patients that present late).[19]

Commissioning to meet the performance indicator should include increased targeting of HIV testing, HIV prevention, condom schemes and information to gay men, African communities and other at-risk groups.

Referral to counselling and related support should be included in line with 2007 NICE guidance on one-to-one STI interventions.

Referral to HIV self management programmes e.g. Living Well programme should be included which show evidence of increased self confidence, health promotion and skills to live well with HIV.

There should be enhanced professional development for primary and community providers to recognise symptoms/presenting conditions of HIV.

Interventions

13. That the Government instate an HIV performance indicator relating to reducing late diagnoses of HIV (see intervention 1). **(Department of Health)**

14. That the Government encourage primary and community providers to increase HIV testing to bring down rates of undiagnosed HIV/late diagnosis. **(Department of Health)**

15. That Government consider including HIV in the list of exemptions from NHS charges relating to STIs as public health benefits of free treatment to control infections outweighs the financial benefits of withholding free treatment. **(Department of Health)**

19 Ibid

8.0 SEXUAL HEALTH SERVICES IN THE COMMUNITY

The Government's policy drive places great emphasis on health in the community, self management, prevention, access to services and reducing health inequalities. Increasing the role of pharmacies, and encouraging new and local providers of services will also improve access for sexual health.

PCTs need to have robust strategies on sexual health aimed at meeting population need. The strategies should be at PCT/Local Authority level so the needs of a diverse economy (for example a combination of rural and urban areas) are comprehensively met.

The IAG is concerned that some PCTs are adopting practice based commissioning without having robust data or an accurate understanding of real costs, patient activity and need for sexual health services.

8.1 General Practice

General practice is an important gateway to sexual health services. GPs could significantly help increase awareness of STIs, especially Chlamydia, and be an effective conduit for HIV screening in the community with the associated increased levels of diagnosis.

8.2 GPs and diagnosing STIs

Although a substantial and increasing number of STIs are diagnosed and treated in general practice (especially Chlamydia),[20] sexual health often remains a low priority for GPs. Much of this is because most GPs are not trained to treat sexual health holistically, and many do not engage in sexual health issues. For example, while a GP will take blood pressure when prescribing the pill they are less likely to take a full sexual history.

A study published in *Sexually Transmitted Infections* found a median delay of 7 days to diagnosis of STI from GUM Clinics, and that approximately 25 per cent of patients had already sought or received care in general practice, and these patients experienced a greater provider delay.[21] Thousands of people with an STI were visiting their GPs each year only to be turned away without diagnosis or treatment – and in some cases without any advice at all.[22]

20 Trends in sexually transmitted infections in general practice 1990-2000, Cassell J, Mercer C, Sutcliffe L, Petersen,I, et al. BMJ 2006: 332.332-334, 11 February

21 How much do delayed healthcare seeking, delayed care provision, and diversion from primary care contribute to the transmission of STIs? Mercer, Sutcliffe, Johnson, Cassell et al, Sexually Transmitted Infections 2 May 2007; 83; 400-405

22 GPs should do more to combat sexual infections, Day, M. BMJ 2007; 335:119 (21 July)

In terms of commissioning from the new GP contract, a recent survey by the All-Party Pro-Choice and Sexual Health Group (APPG) of 122 PCTs found that provision of sexual health service provided by general practices was "erratic, uncoordinated, and poorly planned" showing alarming gaps in both service provision and in PCTs' knowledge of what services were provided.

The report estimates that only 5 per cent of general practices provide testing and diagnosis for sexually transmitted infections, and there is also a wide disparity in the service at regional and local level.[23]

8.3 GPs and Contraceptive Services

Contraceptive service provision by general practice must be improved (see interventions 17 and 21).

The APPG report estimates that 70 per cent of women are not being offered a full range of contraceptive methods by GPs, and PCTs are not targeting services to reduce unintended pregnancies in women over the age of 18.[24]

The pill is far and away the most common form of contraception provided (75 per cent[25]) by GPs and provision of Long Acting Reversible Contraception (LARC) is low.

Many PCTs (47 per cent of those surveyed by the APPG[26]) are unable to say whether LARC provision existed in their PCT. Of those that did know, under two thirds (65.7 per cent) of PCTs provide IUD/IUS.[27] General practice is failing to implement the NICE guidance on LARC.

GPs need to be trained in the provision of a good quality contraceptive service that includes Long Acting Reversible Contraception, and the people that train them – consultants and others within the community contraceptive clinics – are currently under threat.

8.4 GPs and Training

Many GPs are unsupported in changing working practice around sexual health.

Effective training and practical assessment in providing sexual health services is vital to ensure effective practitioners.

The Department of Health is supporting the Royal College of General Practitioners (RCGP) in working with its own profession to address this training gap.

A specialist clinical interest group called the Sex, Drugs and HIV Task Group (SDHIVTG) was established. The SDHIVTG comprises multi-disciplinary interagency stakeholders and functions within Clinical Network of the Royal

23 Delivery of Sexual Health Services in General Practice, APPG survey October 2007
24 Ibid
25 Indicator on LARC, published by Department of Health
26 Op Cit
27 Ibid

College of General Practitioners. It is led by GPs who are key champions of sexual health and of GP education.

In partnership with MedFASH, the SDHIVTG is in the process of producing an introductory course in sexual health specifically for general practice. The course will serve as entry level training for those who may wish to go on to develop further competencies in this area. Sexually Transmitted Infection Foundation Course (STIF) and Diploma of Faculty of Sexual & Reproductive Healthcare (DFSRH) will be recommended as courses for practitioners wishing to develop their skills.

Intervention for GPs

16. That GPs provide increased screening for HIV and other STIs. **(Department of Health)**

9.0 Community Contraceptive Clinics

Community contraceptive services received at least 2.6 million visits from 1.2 million women last year.[28] The clinics serve all populations but in particular provide services for vulnerable women in areas with associated links such as poor primary care, including access and opening hours. They provide choice for women, and often function as outreach for diagnosing and treating STIs and gynaecological problems, as well as meeting contraceptive needs.

Historically, they are a gendered service set up by women for women to champion reproductive health issues. They, like many community services, have suffered from not being accorded sufficient importance within PCT structures.

The Royal College of Obstetricians and Gynaecologists (RCOG) specialty training programme for gynaecologists working within the community has significant emphasis on public health, health promotion and training. The programme works collaboratively with PCT commissioners and managers to design and deliver healthcare appropriate to the local community. It has been strongly supported by Department of Health Workforce Development.

PCT spend on contraception is low. Some PCTs spend as little as 18p per woman per year for contraception.[29] The cheapest brand of contraceptive pills costs about 70p per month. Consider this when, overall, contraception services probably save the NHS over £2.5 billion a year through preventing unplanned pregnancy. Research has shown that for every £1 spent on contraceptive services there is a saving of £10 to the public purse.[30]

Clinics are often ill-equipped to deal with the changes currently underway in NHS commissioning. They are often un-computerised, usually under-funded, and

28 This is recorded data from KT 31 returns. However, because so many records are kept manually rather than being computerised, the number could be considerably higher.

29 Findings of the Baseline Review of Contraceptive Services, p.22, 17 May 2007, Author: DH/Sexual Health and HIV Team, Gateway 7606

30 Armstrong N and Donaldson C The Economics of Sexual Health, London fpa 2005

certainly under-appreciated by PCTs who last year quietly closed a significant number of services to make savings.[31]

The IAG has rehearsed the arguments of the effects of disinvestment and clinic closures in previous annual reports.[32] The IAG also has addressed issues around tariff and PBR roll out in relation to contraceptive services and made recommendations.[33] Community contraceptive services are not appropriately priced at the moment, and until tariff is addressed this will be a significant problem. As mentioned earlier, a pilot on contraception and abortion tariff is underway in London.

Community contraceptive clinics provide clinical leadership and governance on reproductive health for the NHS. This is particularly true in providing training in delivering all methods of Long Acting Reversible Contraception (LARC) to meet NICE recommendations made in 2005.

There is an acute need for the expertise held by consultants and other senior clinicians in the contraceptive clinics in terms of training other health professionals such GPs and practice nurses. At the moment, due to closures, there are not enough consultants or services to train GPs and others.

In crude terms and at a very minimum, health professionals are not going to be able to improve availability of LARC if they are not trained to fit LARCs. If women cannot access effective contraception then the abortion rate will rise.

It seems counterproductive that contraceptive services are under-funded in many parts of the country and are being closed in some areas because of NHS deficits, even though they offer an active and effective community service supporting sexual health and wellbeing.

It is important to understand the economic benefit of having a holistic approach to sexual health. For example, improving access to all methods of contraception – both in terms of the type of contraception and where it is accessed – will have a direct and tangible impact on the costs associated with abortion. Abortion and contraceptive budgets are separate so the cost savings are not immediately apparent to PCTs.

The All-Party Parliamentary Pro-Choice and Sexual Health Group (APPG) concluded that linking the budgets between abortion and contraception might improve contraceptive services.[34] Contraception should form an integral part of commissioning of post-abortion care.

A major Government focus is our teenage pregnancy rates, and our high abortion figures. Disinvestment in community contraceptive services that reach women who are young, financially or socially excluded, and generally fall into categories defined as 'difficult to reach' is counter-productive. The possible impact on training of staff for the future is disastrous, and this will affect all women.

31 Community Contraceptive Services Questionnaire, Faculty of Sexual and Reproductive Healthcare, 20 February 2007, Press Release: New Research: Patients denied access to sexual health clinics

32 Pp. 14-15 Independent Advisory Group on Sexual Health and HIV Annual Report 2004/05 and pp 10 -11 Independent Advisory Group on Sexual Health and HIV Annual Report 2005/06

33 Annual Report 2005/06 and Independent Advisory Group on Sexual Health and HIV response to Payment by Results, DH proforma. Both available from http://www.dh.gov.uk/en/PolicyAndGuidance/HealthAndSocialCareTopics/SexualHealth/SexualHealthGeneralInformation/DH_4079794

34 Delivery of Sexual Health Services in General Practice, APPG survey October 2007

Interventions for community contraceptive services

17. That the Government protects the role of community contraceptive clinics as trainers, service providers and clinical governance leads for the primary care community. **(Department of Health)**

18. That the Government ensures robust commissioning frameworks to implement tariff and dehosting of the funding arrangements to improve procurement of contraceptive services. **(Department of Health)**

19. That the Government ensures contraception forms an integral part of commissioning post-abortion care. Contraception should form an integral part of commissioning post-abortion care. **(Department of Health)**

10.0 Nurses

Nurses' role in sexual health care provision is extremely important. Within many GUM clinics and community contraceptive clinics, nurses prescribe and work to PGDs.

There is an issue about training and general practice. Training is not standardised and often a low priority on both pre-registration and post-registration training. There are courses throughout the country but they are costly and some general practices will not fund nurses to attend them.

There is no nationally agreed content in the modules and the Higher Educational Institutions choose what they offer. However, there are agreed competencies and agreed competency frameworks and work has been started to review the content.

The Department of Health has funded the Faculty of Sexual and Reproductive Healthcare to develop national recommended training standards in contraception, sexual and reproductive health for non-medical healthcare professionals.

Following a proposal by the IAG to look at the issue of nurse training in contraception, it has been decided to merge the projects and the future direction will be decided at a joint stakeholder workshop being run by the Department of Health and the IAG on November 29th 2007. They will be hosted by *fpa* and chaired by Baroness Joyce Gould.

There is a particular opportunity to review the training and role of nurses in sexual healthcare provision with the current initiative from the Nursing and Midwifery Council on modernising nursing careers.

Interventions for Nurse Training

20. That the Government engages with the Nursing and Midwifery Council on modernizing nursing careers, and where sexual health should be developed. **(Department of Health)**

21. That the Government advise that the skills of nurses and other practitioners in general practice are updated and maintained in sexual health and contraception. **(Department of Health)**

11.0 Walk-in Centres and Pharmacies

At the moment, there are 72 walk in centres, with 16 more under development, and 7 pilot commuter walk in centres. These centres offer improved access to services. However, the issues around patient care pathway and levels of experience and understanding in dealing with sexual health issues remain.

Community pharmacies have the scope to provide an increasing greater range of services. The provision of enhanced services through the pharmacy contract requires the accreditation of the pharmacist, accompanied by the relevant additional training, to provide the service. This supports, for example, the anticipated greater role pharmacists will play in Chlamydia screening. The intention is that key stakeholders will develop a national template for a Chlamydia screening service through community pharmacies.

It is possible that services could expand further in providing contraception. It is also anticipated that the forthcoming pharmacy White Paper is likely to include the pharmacy contribution to sexual health in general. Training and competency assessment will be a central tenet for achieving high quality development in the breadth of scope of services provided through community pharmacies.

There are a number of issues around developing the role community pharmacy, and the checks and balances that will need to be put in place. They include what the service will look like, care pathways and how pharmacies will work with the local sexual health services, data collection and training.

12.0 The Third Sector

The role and 'shape' of the third sector for sexual health is changing as voluntary organisations are encouraged to become service providers for the NHS. The devolving of budgets and commissioning to a local level has raised concerns about the impact on central funding to the voluntary sector.

12.1 Funding

The voluntary sector is concerned about the potential impact of reducing investment in national organisations as part of the policy drive to devolve monies to local level.

The investment in national sexual health organizations is a small proportion of the total sum spent on sexual health nationally and locally. The exact figure varies from year to year, but for 2008 is estimated at £4 million. This figure includes funding currently received from Section 64 core and project grants, and sexual health and HIV programme monies for services, prevention initiatives and dissemination of guidance and best practice.

Key activities undertaken by the voluntary sector are under threat if the funding is withdrawn.

These include:

- Specialist information and advice services for the public and professionals.
- Expert advice, guidance and networking for policy makers and professionals.
- Service and workforce, research and development.

The loss of these services through fragmented funding would be significant.

Interventions on working with the Voluntary Sector

22. That Government commit to providing central funding to voluntary organisations. **(Offices of the Third Sector)**

23. That the Compact has greater powers to influence processes around commissioning, and attention is paid to sexual health contracts between the Government and Voluntary Sector. **(Offices of the Third Sector)**

24. That the Government supports the continuation of the AIDS Support Grant. **(Department of Health)**

13.0 Health Promotion and Education

Heath promotion is an integral part of preventing the spread of STIs, HIV prevention, reducing unplanned pregnancies, and giving people sex-positive messages that build self respect and self knowledge.

The IAG believes it is vital that PCTs raise the profile and commissioning of sexual health promotion, HIV prevention and agree a tariff for these services.

13.1 Advertising

It is profoundly depressing that, at a time when STI and HIV rates are continuing to rise, that there is guidance curbing the advertising of condoms on television and radio.

There is, without doubt, a need to review current advertising advice on condom advertising. Condom advertising is restricted before 21.00 (except on Channel 4, when condoms advertising can be shown from 19.00), and condoms cannot be shown out of wrapper before 22.30 (if at all).

These restrictions are unusual in the European Union. Germany, Spain, France, The Netherlands and Sweden have no such restrictions.

A survey carried out by young people at Brook[35] shows that most young people (91 per cent) were unaware that guidance exists prohibiting showing unwrapped condoms on television and many (90 per cent) thought that this was wrong. 81 per cent felt that allowing condoms and condom use to be shown in advertisements and programmes would encourage young people who were sexually active to use condoms.

The survey shows that young people believe that, after good SRE in schools and free provision of condoms through sexual health services, television is the most effective way of encouraging young people to use condoms.

The IAG is concerned there is still embarrassment around condoms, which inhibits the normalisation of condom use. A recent survey by *fpa* indicated that most people – regardless of age – found talking about condoms with a new partner very embarrassing and 36 per cent said it is such a tough conversation it makes them less likely to use a condom.[36]

The Committee of Advertising Practice plans to review all its advertising guidance in the near future, and the IAG recommends a specific review of condom advertising.

It is time to take a more mature attitude to condoms and condom advertising.

35 Showing condoms on TV: what young people think (Brook 2007).
Methodology: paper questionnaire, self selecting and anonymous. 79 fully completed questionnaires were received. The age range of respondents was 14 to 24 and over half (46 of them) were 16-19.
36 Press Release: Brits blush talking about using condoms with their partner says fpa August 2007

Intervention on Condom Advertising

25. That the guidance around condom advertising is reviewed. **(Department for Business, Enterprise and Regulatory Reform)**

26. That the Commercial Directorate procures condoms for as much of the NHS as possible to increase access and get better value. **(Department of Health)**

13.2 Issues relating to Sex and Relationships Education (SRE) and Personal Social and Health Education (PSHE)

There have been some optimistic developments around improving the provision of sex and relationships education as part of PHSE in schools. PSHE and SRE is an area where cross departmental working is extremely important.

The PSHE Subject Association was launched in February 2007, a vital step in giving PHSE stature and helping raise the quality of teaching. All curriculum subjects have a subject association.

NICE has been referred to produce Guidance on Schools, College and Community-based Personal, Social and Health Education. The Guidance is due to be published in September 2009.

The IAG published a report on *Sex, Drugs, Alcohol and Young People*[37] which, as well as demonstrating the link between alcohol and drugs misuse and risky sexual behaviour, also explored the impact of Britain's obsession with 'celebrity' culture, and messages received through media and advertising. As part of the strategy for tackling these issues, the IAG called for a national joined-up strategy for young people's services, and statutory SRE in school.

Initial response from ministers indicates that the recommendations of the report will be considered for the revised alcohol strategy and the new drugs strategy which the Government will consult on later in the summer. The IAG will also feed into the NICE guidance on school based interventions on alcohol.

Young people have also called for improvements in sex and relationships education.

A recent on-line survey of girl guides showed 80 per cent of 16-25 year old Guides want advice on safe sex.[38]

The UK Youth Parliament launched the results of a survey among 21,602 young people ascertaining levels of Sex and Relationships Education in schools across the country. Only 55 per cent of respondents had been taught about teenage pregnancy, 61 per cent of boys and 70 per cent of girls over the age of 17 reported

37 Sex drugs alcohol and young people – A review of the impact drugs and alcohol have on young people's behaviour, Independent Advisory Group on Sexual Health and HIV, June 2007

38 Self-Defense, Cyber-Safety and Saving-Cash -Top Ten Skills for the Modern Girl, on-line survey by Girl Guides published July 2007

not having received any information about personal relationships at school, and 73 per cent of all respondents felt that SRE should be delivered under the age of 13.[39] The IAG supports the UK Youth Parliament's call for statutory SRE in schools.

13.3 What Young People Are Asking For

Young people, when questioned, consistently ask for services provided by friendly staff, situated in places where they are. Outreach is effective but can be complex to commission.

Brook will soon publish the first national guide to sexual health outreach work, based on the TPU deep dive findings that showed that one of the factors in reducing conception rates was good outreach work.[40] The IAG believes that this positive approach to outreach could and should be applied to adult services.

13.4 HPV Vaccine

The introduction of the vaccine for HPV for girls entering secondary school has been approved. From 2008, the vaccine will be administered to girls aged 12 to 13 years old, with a catch up programme for girls aged 14 to18 years old, which the IAG applauds.

Used in conjunction with screening, the vaccine represents extraordinary benefit in terms of helping reduce rates of cervical cancer.

It is also an ideal opportunity to promote more comprehensive sex and relationships education as young people should be told why the vaccine is necessary, and how they can protect themselves against other STIs and unwanted pregnancies.

Prevalence of carcinoma in situ (CIN 3) has increased in women aged 20-24, which is consistent with more women in recent birth cohorts starting sexual activity in their mid-teens.[41] We know that more women are sexually at a younger age, and often with multiple partners.

Ambition, and having ambitious parents, has been identified as one of the best contraceptives for young people.[42] PSHE is a way of making the playing field equal and ensuring all young people are versed in the issues around sex and relationships education, teenage pregnancy, contraception, and STIs.

39 SRE – Are you getting it? A report by the UK Youth Parliament, published 2007
40 A Guide to Sexual Health Outreach Work, Teenage Pregnancy Unit and Brook. Call 020 7284 6052 for more information
41 Cervical Screening – Women under 25 should be offered screening, Herbert, A, and Smith, J, BMJ, 10.2.07. vol 334 pp 273
42 Sex drugs alcohol and young people – A review of the impact drugs and alcohol have on young people's behaviour, Independent Advisory Group on Sexual Health and HIV, June 2007

13.5 Reaching Young People

The Government is working to reach young people with messages around safe sex with the Condom Essential Wear campaign and other campaigns targeting young people. The Condom Essential Wear campaign is gearing up to the second stage of execution – "I'll screw you"...

This work would be even more powerful if every young person in the country was receiving consistent education and messages about safe sex, good relationships, and avoiding teenage pregnancy.

Intervention

27. That the Government ensures that sex and relationships education is a statutory part of PHSE. **(Department for Children, Schools and Families)**

14.0 Chair's Activity

The Chair presents a written report on her activities to every meeting of the Advisory Group. Over the past year she has continued to ensure that sexual health is appropriately evaluated not only in terms of prevention, provision, funding and standards but also how sexual health as a topic is addressed, whether this is, for example, in PSHE/SRE in schools or in the media and advertising.

This year, Baroness Gould in addition to bringing attention to various aspects of sexual health through speeches, articles, visits, addressing conferences and hosting events, has held two seminars and commissioned a review of the Sexual Health Strategy.

The Chair has maintained a dialogue with Government Ministers and senior officials, and subsequent to the ministerial appointments of the new Prime Minister, Gordon Brown, she arranged a special meeting of the Advisory Group to establish an early exchange of views with the new Minister of State for Public Health, The Rt Hon Dawn Primarolo MP; and met with Professor The Lord Darzi, Parliamentary Under-Secretary of State at the Department of Health who has been made responsible for the NHS next-stage review.

This year, Baroness Gould became the first Honorary Fellow of the British Association for Sexual Health and HIV [BASHH].

14.1 IAG Meetings

- 6 December 2006
- 7 March 2007
- 19 June 2007
- 12 September 2007
- Special meeting 25 October 2007

14.2 Seminars

- Sex, Drugs, Alcohol and Young People – 18 January 2007
- Public Health Policy and HIV/AIDS – 10 October 2007

14.3 Response to Consultations

- Primary Care Service Framework Improvement Foundation, Public Health (Control of Disease) Act 1984
- Health and Social Care Outcomes and Accountability Framework
- Abortion Act Science and Technology Committee Inquiry (Commissioning mid-trimester abortions, the evidence base for need)
- Payment by Results (response to DH proforma)

14.4 Publications

- Sex, Drugs, Alcohol and Young People – 15 June 2007
- Newsletter 4 (April) Newsletter 5 (October) HIV/AIDS focus

List of IAG Members

Chair
Baroness Gould of Potternewton

Joint Vice Chairs
Anne Weyman OBE, *Chief Executive, fpa*
Derek Bodell *Consultant, former Chief Executive, National AIDS Trust*

Strategy and Implementation Special Adviser
Professor Michael Adler *CBE Professor of Genitourinary Medicine, Royal Free and University College Medical School.*

Senior Health Promotion Expert
Stephen Slack *Director of the Centre for HIV and Sexual Health*

Public Health Expert
Helen Ward *Senior Clinical Lecturer in Public Health and Honorary Consultant in Genitourinary Medicine at Imperial College London. On secondment as a consultant epidemiologist at the Centre for Infections, Health Protection Agency.*

General Practitioners
Dr William Ford-Young *GP, Macclesfield, lead on Sexual Health and HIV for Eastern Cheshire PCT*

Consultants in Family Planning/Community Gynaecology
Dr Connie Smith, MBE *Co-director, Westside Contraceptive Services, Westminster PCT*

Consultants in Genitourinary Medicine
Dr Patrick French *Consultant in Genitourinary Medicine, Camden PCT, Honorary Senior Lecturer at the Royal Free University College Medical School*
Professor George Kinghorn *Consultant in Genitourinary Medicine, Clinical Director for Communicable Diseases, Sheffield Teaching Hospitals NHS Foundation Trust, Honorary Professor of Genitourinary Medicine, University of Sheffield*

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